Intimate Partner Violence Screening: A Nursing Concern?

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Introduction

One of the Healthy People 2020 objectives is to "reduce violence by current or former intimate partners" (United States Department of Health and Human Services, 2011, p. 16). Several health organizations such as the American Medical Association, American Nurses Association and the American Association of Colleges of Nursing have recommended routine screening for IPV. This is due to the many negative health associations with intimate partner violence (IPV). About one fourth of women and one ninth of men over age 18 in the United States have experienced IPV (Centers for Disease Control, 2008). Approximately 15% of adults in the United States report having been a victim of IPV and three-fifths of adults report knowing someone who has been a victim of IPV (Krane, 2006). These victims may attend medical visits for trauma or for a wide range of other symptoms. It has been found that the majority of women with headaches, stomach problems, chronic pain, vaginal bleeding, substance abuse, depression, and suicidal thoughts have experienced lifetime physical and or emotional abuse (Kramer, Lorenzon, & Mueller, 2003). Campbell, Jones, Dienemann, Kub, Schollenberger, O'Campo, Gielen, & Wynne (2002) found that victims of IPV have increased sexually transmitted infections, gynecological disorders, gastrointestinal disorders, central nervous system disorders, chronic stress related problems, and circulatory disorders. Silverman, Raj, Mucci and Hathaway (2001) found that IPV is associated with several behaviors that have a negative impact on health such as engaging in high risk sexual behavior, using harmful substances, using unhealthy weight control methods, suicidal thoughts and attempts, and adolescent pregnancy. Intimate partner violence is also prevalent during pregnancy, placing the mother and child in danger. Fulton (2000) found that abused women do not receive prenatal care until as late as the third trimester and experience a higher rate of complications.

Intimate partner violence has many negative health associations which increase the importance of screening and awareness in the hospital setting. With all of this information, it seems ethically correct to screen patients for IPV. However, it is not always current practice. Currently there is no standard screening tool or protocol to help identify victims of this abuse and screening is consistently not being done. The purpose of this paper is to outline the lack of screening for IPV in spite of its prevalence and adverse health effects, the barriers that hinder screening, if all of those barriers are well founded, and ways to increase screening. This will ultimately inform healthcare providers about the ethical dilemma at hand and the need to increase IPV screening in future practice.

The Problem

The aforementioned negative health associations and recommendations from various groups have not transformed the practices in healthcare settings. Many studies have demonstrated the lack of routine IPV screening and the barriers to screening by nurses. Kramer, Lorenzon and Mueller (2003) found that only 25% of women had ever been asked about IPV. In a study by Miller, Decker, Raj, Reed, Marable and Silverman (2010), only 30% of urban adolescents were screened in their lifetime for IPV when 40% had experienced it. Out of 645 women aged 15-24 in family planning clinics, 45% reported having been abused by a partner and only 55% of those who were abused reported having been asked by a provider about the abuse (Breitbart & Colarossi, 2010). In another study, only 7% of all charts had IPV screening documented (Owen-Smith, Hathaway, Roche, Gioiella, Whall-Strojwas, & Silverman, 2008). Yam (2002) found that abused women felt that health care providers did not understand IPV and often blamed them for abuse, were unconcerned and not compassionate, or did not address the issue of IPV at all. There are many reasons documented for this lack of screening. In a study by Robinson

(2009) reasons for not screening included a lack of time and training, frustration when victims return to the abuser, views that IPV is not a health problem but a social problem, and that victims view screening as offensive and will not be truthful or follow advice. In another study, barriers include forgetting to screen, discomfort with screening, time constraints, patients having more immediate problems, patients being accompanied by family, fear that the documentation might end up in the wrong hands, and uncertainty about the best way to document (Owen-Smith et al., 2008). Felblinger and Gates (2008) found that nurses did not feel that they had adequate training to care for IPV victims and were not aware of policies in their workplace. Jeanjot, Barlow and Rozenberg (2008) found that the lack of screening was due to fear of shocking the patient, cultural barriers and lack of training in managing the problem. In a study by Yonaka, Yoder, Darrow, Sherck (2007), barriers to screening identified by emergency room nurses were a lack of education on how to ask questions about IPV, language barriers between nurses and patients, a personal or family history of abuse, and time issues. There is a common consensus that there is a lack of screening for IPV, as well as several common themes that have been identified for the lack of screening.

Overcoming the Barriers

Due to the importance of screening and the lack of screening for IPV, it is important to look at ways to overcome barriers and implement IPV screening in the medical setting. Barriers such as offending and shocking patients, being able to tell a victim by looking at them, lack of comfort with screening by healthcare providers, the view that women will lie, the lack of time, the presence of friends and family with the patient, forgetting to screen and document and a lack of training are all capable of being overcome as demonstrated through many studies. Eighty three percent of women welcome abuse screening and 86% would disclose abuse if asked

directly, respectfully, and confidentially (Kramer et al., 2003). Women welcome screening when the provider does it in a nonjudgmental, compassionate and sensitive way while maintaining confidentiality and understanding the complexity of IPV (Feder, Huston, Ramsay, Tacket, 2006). Breitbart and Colarossi (2010) found that women preferred speaking about IPV with a health provider over their mother or a counselor and women thought screening provided a means of education and acknowledges IPV as a health concern. It has also been shown that patient characteristics and clinical presentations are not able to consistently predict IPV (Zachary, Mulvihill, Burton, Goldfrand, 2008). The use of language that is not stigmatizing and constraining such as "physically hurt" instead of "abused" with answer options of "always, often, sometimes, seldom or never" instead of "yes or no" increases the likelihood of women reporting violence by four times (Breitbart and Colarossi, 2010). In another study, strategically placed posters and brochures that disseminated information without directly pointing out a woman in front of the abuser, training for providers and questions placed on health questionnaires increased case finding 1.3 fold and documented IPV screening 3.9 fold (Thompson, Rivara, Thompson, Barlow, Sugg, Maiuro, Rubanowice, 2000). A study by Thurston, Tutty, Eisener, Lalonde, Belenky, and Osborne (2009), found that helping nurses understand the purpose of asking about IPV, quickly recognizing problems, validating staff concerns, and adapting procedures helped incorporate universal screening into routine nursing practice. Breitbart and Colarossi (2010) found that providers could adequately screen without interrupting their work flow. In the study by Owen-Smith et al. (2008), additional suggestions to increase screening include adding screening questions to intake and follow up forms, sending email reminders to nurses and intermittent and mandatory IPV training.

Conclusion

There is a disconnect between the prevalence and negative health impact of intimate partner violence and the current screening practices in spite of the evidence of ways to overcome the barriers and increase intimate partner violence screening. The lack of screening needs to be addressed so that health care providers are not overlooking an important health care concern in the lives of many patients. This will allow healthcare providers to fulfill their role as advocates and protectors of health. Assessing intimate partner violence in patients falls into the scope of a nurse. Nurses are on the front line in the hospital, assessing and communicating with patients every day. They are in an excellent position to screen and have a responsibility to advocate for their clients as holistic beings which includes the health of their intimate relationships in addition to their immediate health concerns. Despite there being barriers to implementing screening, it is the ethical obligation for nurses to address this health concern and find ways to overcome the barriers. This could be through working to identify barriers specific to their hospital unit or clinic and their personal beliefs and implementing systemic and personal changes in those designated areas, learning about and being an advocate for policies in the workplace and in the government as well as research. Learning about the issue of intimate partner violence can help raise awareness of the problem and how to assess and respond to it and resources available in the community. Nurses have great influence and manpower to be able to assess and combat intimate partner violence. In spite of the difficulty of assessing for intimate partner violence, nurses have an ethical duty of beneficence and that duty to the patient outweighs the barriers nurses may face. The American Nurses Association (2001) Code of Ethics for Nurses states that the nurse "promotes, advocates for, and strives to protect the health, safety and rights of the patient" (p. 6).

Nurses have an ethical duty to screen for intimate partner violence to fulfill this role as laid out by the American Nurses Association.

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